Dental Insurance Enrollment/Change Form

CIGNA
A Business of Caring.

INSTRUCTIONS: *Top box to be completed by the Employer/Plan Sponsor. Remainder to be completed by the Employee.*

Name of Employer/Plan Sponsor:	**Group/Plan:**	**Agency/Department Name:**	**Agency/Department Number:**
North Dakota Public Employees Retirement System	**3328472**		

This change is due to:

☐ Initial Eligibility Following Hire
☐ Annual Enrollment
☐ Late Entrant due to Change in Family Status*
☐ Change Agency from _____ to _____
☐ Address Change
☐ Add Dependent
☐ Delete Dependent
☐ Cancel Coverage
☐ Loss of Other Coverage
☐ Termination
☐ Retirement

Effective Date of Coverage or Change:

* A late entrant is an individual who is first enrolling for dental coverage after the first available opportunity.

Employee Name *(last, first, middle initial)*	☐ Female ☐ Male	Date of Birth / /	Social Security #
Employee Address *(street address, city, state, zip code)*	☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated		Telephone Work ( ) Home ( )

Elect or Decline Coverage

Elect Dental Coverage	☐ **Employee Only** ☐ **Employee + Spouse** ☐ **Employee + Child(ren)** ☐ **Employee + Family**
Waive Dental Coverage	**IF YOU DO NOT WANT COVERAGE, COMPLETE THIS SECTION.** I have been given an opportunity to apply for Group Dental Insurance and have decided waive coverage for: (check all that apply) ☐ myself ☐ spouse only ☐ child(ren) only ☐ myself and entire family

Dependent Information *Complete for covered spouse and each covered child. Attach separate sheet if more room is needed.*

Dependent Name *(last, first, middle initial)*	Relationship to Employee	Gender (F or M)	Date of Birth	Marital Status*	Child Status**	Add or Delete

* For Marital Status, enter one of the following: Single, Married, Divorced, Widowed, Legally Separated.
** For Child Status, indicate "S" if full-time student or "H" if handicapped, or leave blank if neither.

Other Dental Coverage Information *Complete if you and/if any dependent have dental coverage with another insurer or carrier.*

Employee/Dependent Name *(last, first, middle initial)*	Name and Address of Other Dental Insurer/Carrier	Policy/Plan Number	Effective Date	Other Dental Coverage Type
				☐ Single ☐ Family
				☐ Single ☐ Family

READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW⬇

- I authorize my employer to deduct from my wages the premium, if any, for the elected coverage.
- To the best of my knowledge and belief, the information I have provided on this form is correct.
- **I understand that any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information, commits a fraudulent act, which is a crime.**
- I understand my coverage begins on the effective date assigned by CIGNA HealthCare, provided I am actively at work.

Employee's Signature	Date Signed / /

Enter your name, gender, date of birth, social security number, mailing address, marital status, and telephone numbers.

Elect Coverage

Select the level of coverage. If electing Employee + Spouse, Employee + Child(ren), or Employee + Family, complete spouse and dependent coverage information. If you are adding or dropping a spouse or dependent, ensure that you check the appropriate box.

Waive Coverage

Select who is waiving coverage.

Other Dental Coverage

Indicate if you and/or any dependent have other dental coverage.

You must sign and date this form for it to be valid.